

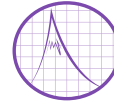
PEAK MEDICAL GROUP

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POST COVID-19 PULMONARY FUNCTION TESTING (PFT) REFERRAL FORM



PEAK MEDICAL
SPECIALTY CENTRES



PEAK PULMONARY
FUNCTION LABORATORIES



PEAK SLEEP CLINIC



PEAK OXYGEN



PEAK RESEARCH
GROUP

PATIENT DEMOGRAPHICS (PLEASE PRINT OR AFFIX LABEL)

Last Name: _____ First Name: _____ PHN: _____

Date of Birth: _____ Sex: M F Identify as: _____ Phone Number: _____

Address: _____

POST COVID-19 QUICK REFERENCE TOOL

Patient was hospitalized (ie. admitted as an inpatient) for any length of time for the treatment of COVID-19	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Patient was treated at home for COVID-19 or suspected COVID-19 and has ongoing respiratory symptoms	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes to either of the above, consider a referral for a full PFT (Spirometry + lung volumes + diffusing capacity/DLCO) 3 months since the onset of COVID-19 infection or discharge from hospital.

Patient was hospitalized or treated at home and has concerning respiratory symptoms at any point in time since the resolution of acute COVID-19	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Consider immediate referral for a full PFT (Spirometry + lung volumes + diffusing capacity/DLCO).

This quick reference tool was created with the guidance provided from the Alberta Health Services Medicine Strategic Clinical Network for the use of Pulmonary Function Testing (PFT) following COVID-19 infection.

Documentation of serial lung function decline following COVID-19 infection, even in previously hospitalized asymptomatic patients, could be of value to detect restrictive lung disease. All patients who have had confirmed or suspected COVID-19 infection should be periodically reassessed for the possibility of ongoing respiratory symptoms. Regarding the frequency of follow-up PFT testing in these patients, consider a Respiriology Consult.

Referral for Full PFT

Referral for Full PFT & Respiriology Consult
(please include reference letter)

CLINIC AND REFERRING PHYSICIAN (PLEASE PRINT OR STAMP)

Referring Physician (please print): _____

Clinic Address (or Clinic Stamp): _____

Date: _____

Signature: _____

Please note some services listed are not covered by Alberta Healthcare.
We will contact the patient to book the appointment.

PATIENT COVID-19 DETAILS & INFORMATION

Covid-19 Infection Date: _____

Symptoms: _____
